



Report to the Board of Directors

Ad Hoc Committee on Audiology Outcomes Measurement

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Background

The Board's Resolution 18-2013 established the Committee in response to recommendations stemming from ASHA's Changing Health Care Landscape Summit. One of the key recommendations was for ASHA to "develop tools that would allow practitioners to accurately collect and mine data related to patients' auditory and vestibular impairment. The development of a model that would assist in the determination of the amount of care a patient requires from an audiologist is also needed." The charge to the Ad Hoc Committee on Audiology Outcomes Measurement was to make recommendations to the Board by August 2014 as to how ASHA should address the following four questions:

1. What data are needed by whom and for what purposes?
2. What is the appropriate role for ASHA to play?
3. What are the ramifications of failure to act?
4. If multiple data collection efforts are needed within audiology, what is the relative priority of each?

The Committee conducted its work via conference calls, "homework" assignments, and a face-to-face meeting at the ASHA National Office in April. Representatives from the American Academy of Audiology (Therese Walden) and the Academy of Doctors of Audiology (Brian Urban and Kim Cavitt) attended part of this meeting at ASHA's invitation. In addition to the Committee members, representatives from ASHA's National Office Facilitating Team (Neil DiSarno and Margaret Rogers), Government Relations and Public Policy (Lisa Satterfield), and ASHA's National Center for Evidence-Based Practice in Communication Disorders (Jaumeiko Coleman) participated in the conference calls and at the face-to-face meeting.

Legislative and Regulatory Landscape

Recent changes in health care reimbursement have originated in legislative statute and regulatory policy and aim to transition payment from *fee-for-service* (payment by procedure) to payment based on quality and outcomes (*pay-for-performance*). The Centers for Medicare and Medicaid Services (CMS) has been compelled by legislation to require quality reporting in all settings, with the Physician Quality Reporting System (PQRS) the emphasis for outpatient services. Introduced as an incentive-based initiative in 2006, PQRS has since been amended by the Affordable Care Act to be a permanent, penalty-based program tied to the public reporting of quality measures for consumer selection of providers. PQRS started as a process-based quality reporting system, but, following the lead of Congress, has expanded to require measures that cross the National Quality Strategy Domains (patient-centered care, patient safety, care coordination, population health, efficient use of health care resources, and clinical effectiveness). The 2014 Medicare Physician Fee Schedule also included the use of Qualified Clinical Data Registries (QCDRs) as an option for participation. Among other criteria, QCDRs must include quality and outcomes reporting for all payer types (not just Medicare), have benchmarking and comparison capacity, include risk-adjusted data, and have the ability to report participant data publicly. More recent legislative proposals include further expansion of quality and outcomes reporting, mandating registry participation, implementing stiffer penalties for nonparticipation, and applying a payment ranking system based on quality scores.

The payment changes affect all provider types, including colleagues in otolaryngology, physical therapy, and occupational therapy. The American Academy of Otolaryngology–Head and Neck Surgery (AAO-HNS) works closely with the American Medical Association (AMA) for measure development, but at this time does not have measures that meet the new criteria. The American Physical Therapy Association (APTA) plans to develop a QCDR to meet the CMS requirements for PQRS, though the current PQRS measures used by their membership are owned by the AMA and other groups. The American Occupational Therapy Association (AOTA) uses many of the same measures as physical therapy and has not yet explored the QCDR option. At this time, audiology participation in PQRS is limited to four items that

document (1) process, (2) quality measures that indicate the documentation of medications in the patient record, (3) a referral to a physician for a patient diagnosed with dizziness or benign paroxysmal positional vertigo (BPPV), and (4) an optional measure of screening for depression (anticipated for deletion by PQRS in 2015).

Recommendations

Question 1. What data are needed by whom and for what purposes?

RECOMMENDATION 1: ASHA should develop a data collection system to address the needs of the following stakeholders: payers and policymakers, patients, audiologists providing direct clinical services and their administrators, researchers, and caregivers.

RECOMMENDATION 2: This data collection should enable audiologists to describe their impact on:

- Increased patient quality of life
- Increased patient engagement in social situations
- Decreased need for social support services
- Reduced health care expenditures that could be realized by establishing the audiologist as the first health professional seen by patients with a primary complaint of hearing loss and tinnitus and among the first line of professionals seen by patients with balance/vestibular problems
- Reduced burden of disability
- Reduced caregiver burden
- Reduced risk of falls
- Reduced adverse events from falls
- Reduced educational costs for pediatric patients
- Outcomes subsequent to auditory rehabilitation
- Outcomes associated with involvement of an audiologist as early as possible
- The number of sessions needed to make progress
- Value as a function of outcomes divided by costs

RECOMMENDATION 3: This data collection should be designed as a “learning” system in that the data should inform improvements in clinical practice. Furthermore, clinical practice should inform the evolution of what data are collected and how those data are collected.

RECOMMENDATION 4: Patient-reported and clinician-reported outcomes data should be collected.

Question 2. What is the appropriate role for ASHA to play?

RECOMMENDATION 5: ASHA needs to take the lead in the design and development of a data collection system meeting the needs outlined in Questions 1 and 2. Specific activities include the development and administration of a data collection infrastructure, standardization of existing data elements, development and testing of new measures where no suitable measures currently exist, recruitment of participants, analysis/dissemination of data, and using the data for advocacy and educational purposes, such as impressing upon the public the devastating effects of hearing loss and the negative correlates of untreated hearing loss.

RECOMMENDATION 6: ASHA should explore possibilities for input from other professional audiology organizations as stakeholders who may provide value to this endeavor.

Question 3. What are the ramifications of failure to act?

In the near future, payment systems are highly likely to differentially base payment on the “quality” of the provider. Public reporting of quality metrics will also be the norm. These pressures heighten the need for outcomes measures that can accurately account for the quality of the services provided. If ASHA does not take the initiative to identify and/or develop the measures to be used in assessing the quality of audiology services, audiologists face the very real prospect of being evaluated using inappropriate measures potentially developed by non-audiologists for purposes that may have little bearing on the quality of audiology services. A failure to determine the measures upon which audiologists will be judged threatens the autonomy of the profession, the validity of the results, and the sustainability of the profession.

RECOMMENDATION 7: The Board should give the issue of audiology outcomes its highest possible priority.

Question 4. If multiple data collection efforts are needed within audiology, what is the relative priority of each?

It is envisioned that a single data collection and reporting system, perhaps with multiple “modules,” could meet the many needs outlined in Questions 1 and 2. It is acknowledged that many of the data elements envisioned may be already collected in some manner by individual audiologists, and it is likely that there will be overlap among the particular data elements needed to achieve the different ends outlined above.

RECOMMENDATION 8: Highest priority should be attached to those elements of data collection and analysis that are most likely to have an impact on continued reimbursement of audiology services and are most likely to inform the question of what benefits are associated with auditory rehabilitation.

Next Steps

RECOMMENDATION 9: ASHA National Office staff and member content experts should create an initial design of the data collection system. This design would be widely circulated for comments from ASHA audiology members and other audiology professional organizations and will help to identify terminology issues, technical infrastructure requirements (e.g., whether the existing NOMS platform can be utilized), reporting burden, missing data elements, and the need, if any, to develop new measures.